PRIVACY RELEASE STATEMENT

NAME:_____ BIRTHDATE:_____

ADDRESS:_____ CITY/ZIP:_____

PHONE:(H)_____(W)_____SSN/TAX ID #_____

TODAY'S DATE_____EMAIL ADDRESS_____

PLEASE DESCRIBE BELOW THE NATURE OF YOUR CONCERN OR REQUEST:

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My signature on this page allows Congressman Joe Schwarz, M.D. to contact appropriate officials, forward correspondence, discuss the matter, and receive pertinent information from local, state and federal agencies. It is my understanding that this form is being used in compliance with the Privacy Act of 1974.

I authorize the _____ (Name of Agency) to release the necessary information regarding my case to Congressman Joe Schwarz, M.D.

Signed: _____

Please return this form to:

or Fax: 269-965-9036

Congressman Joe Schwarz, M.D.
249 W. Michigan Ave.
Battle Creek, MI 49017